FOSTER CHILD CERTIFICATION FORM

I have been informed of the following requirements for coverage of a foster child under Option C of the federal employee's Group Life Insurance Program and/or the Federal Employees Health Benefits Program.

1) The child must be unmarried and under the age of 22. (If the child is over age 22, he/she can only be covered if incapable of self-support because of a disabling condition that began before age 22. I must provide documentation of this to my employing office.)
2) The child must be living with me.
3) The parent-child relationship must be with me, not with the biological patent. This means that I am exercising parental authority, responsibility and control. I am caring for, supporting, disciplining, and guiding the child; and I am making the decisions about the child's education and health care.
4) I must be the primary source of financial support for the child.
5) I must expect to raise the child to adulthood.

I understand that if the child moves out of my home to live with a biological parent, he/she loses coverage and cannot ever again be covered as a foster child unless the biological parent dies, is imprisoned, or becomes incapable of caring for the child due to disability, or unless I obtain a court order taking parental responsibility away from the biological parent.

This is to certify that: _____lives with me and we have a regular parent-child relationship as described above. I am the primary source of financial support and intend to raise _____ to adulthood.

I will immediately notify my employing office (and the health benefits carrier if the child is covered under FEHB) if the child marries, moves out of my home, or ceases to be financially dependent on me.

_____ (Print name of employee/annuitant)

_____ (Employee/annuitant Social Security Number)

_____ (Signature of employee/annuitant)

_____ (Date)